Should You Form a Group?

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• In this discussion, greatest emphasis has been placed upon the personal factors involved, rather than upon the mechanical aspects of creating and maintaining a group, since it is the personal factors, the authors say, that are the most often overlooked.

SHOULD YOU FORM A GROUP? "Probably not," we should say, on the basis of the accumulated experience of medical men in partnerships and groups. Since there have always been more failures than successes among such ventures, it would be unfair not to make this initial warning. Actually, however, there is no general answer to this question, for it infers a number of more specific questions, the answer to each being critical in determining success or failure.

The major questions (or tests to be met in forming a group) are the following: How should you organize a group? Which kind of group should you form? With whom should you form a group? How should you finance a group? Where should you form a group? How can you perpetuate a group?

We can undertake herein merely to highlight a few of the most important points involved in each question and to cite some cases that give especially clear-cut demonstrations of the basic principles. First, however, must be stated a workable definition of a group. Dickinson, in his economic and statistical studies for the American Medical Association, considered a group to be any partnership or association of three or more physicians whose practices employ common administrative facilities. These groups were subclassified into *general* groups and *specialist* groups, the one made up entirely of general practitioners, and the other of physicians either in the same or in related specialty fields. Dickinson also recognized *mixed* groups in which there are both general and specialized practitioners. However, this division by type of practice is too general to help greatly in analysis. Therefore, we will consider in addition to the above, two main lines of functional classification. These are the *independent* and the *integrated* group.

In the *independent* group, each member exclusively serves his own clientele, with the group's organization exclusively on the "housekeeping" level. Its advantages over solo practice are those of combined purchasing power for facilities, staff and services; it satisfies the gregarious instinct while preserving the practitioner's feeling of sole proprietorship in his practice.

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In the *integrated* group, all patients are considered and treated as patients of the group, rather than of the individual members thereof. In both general and specialist groups, the common factor is the merging of services by individual physicians to the greater advantage of their patients than is possible through their separate efforts. Where members are all general practitioners or pursuing a single specialty (an additional cross-classification, the *homogeneous* group) this takes the form of interchangeable handling and service for all the patients, on the basis of providing them greater protection. Where the physicians follow related specialties (another cross-classification, the *heterogeneous* group) this takes the form of diagnostic-therapy clinics, of which most large groups are examples.

We will thus consider four significant functional classifications—independent-homogeneous, independent-heterogeneous, integrated-homogeneous, and integrated-heterogeneous, as we look for answers to our six key questions.

1. *How should you organize a group?*

The various legal instruments available include the partnership, the joint venture (or limited partnership), and the association or corporation. The independent group, where each maintains his own practice, may well be effectively set up through a joint venture or corporation, the instrument of organization serving primarily as a housekeeping agency, thus limiting the professional and financial liability of each member to his own actions and the amount of his investment.

The integrated group, with each member accepting his share of the professional liability of all the members, usually takes the form of the true partnership. Here each member acknowledges responsibility for the actions of all his partners, and for their financial involvements as well. While this is only proper

from the professional viewpoint, it can cause serious difficulties when members' financial interests are thus interrelated, especially if one or several of them are engaged in extensive outside activities.

The use of the "partnership entity" theory in large groups has advantages in assuring the continuity of the organization and to some extent limiting the financial liability of each member, and in avoiding the necessity of reforming the partnership with each change in membership. With very large groups a corporation can be a most convenient device for holding the physical assets, since the ownership of its shares can generally be more easily transferred than a partnership interest in such assets (especially where the wives of partners are involved through community-property law).

The choice of any particular form of organization, or combination of the above, must depend on the basic needs and goals of the group's members, and generally the simplest legal framework that will meet these needs is the best. At the same time, the legal implications of the structure selected must be fully understood; otherwise trouble is almost a certainty. When tax questions are involved, both written agreements and actions of the group become subject to scrutiny, and courts often accept whichever interpretation creates the heavier tax liability.

Considering the general partnership as the customary basis of a group, its organizers should formulate an agreement which states and protects their mutual desires and purposes. All major eventualities must be provided for by statements of general intent and definition along the following outline: (a) purpose and duration; (b) duties and responsibilities; (c) ownership of assets; (d) definition of income; (e) definition of expense; (f) division of net income; (g) status and rights during partial or total disability or military service; (h) termination—voluntary, disability, military service, retirement or death; (i) termination rights and mechanisms; (j) admission of new partners; (k) arbitration medium and agency; and (l) special provisions, including rights to disburse funds, to undertake personal or third-party obligations, and the like.

The use of such a check-list of subjects to be covered is essential in assuring that no important area of intention is overlooked. By themselves, these points merely provide an outline or a guide to be used in reaching a sound initial understanding, particularly on matters involving death or future disagreement. They are certainly no substitute for the function of legal counsel in stating these intentions in proper terms, but their application, in the hands of advisors experienced in medical administrative problems, is essential to a sound beginning. Once put into operation, the agreement must be observed sincerely, and where changing circumstances require a different course of action, it should be provided for by amendment or addition to the agreement itself.

In addition to the legal aspects of forming a group, there must also be considered the operative organization. The approach chosen depends in part upon the size of the group and the degree of administrative complexity, in part upon the desire of the group members to concern themselves with such matters, and in part upon seniority.

In small groups, each member may satisfactorily be assigned a certain area of responsibility, preferably one in which he shows a particular interest and ability. This is especially important in directing the staff, where there must be a recognized chain of responsibility and authority. Other functions, such as financial supervision, building and equipment planning, and coordinating the purchase of supplies, should be similarly assigned, either on a permanent or rotating basis.

In groups where one man is much the senior in status or reputation, he is too often found to be acting not only in all these capacities, but also to be directing policy and making decisions without regard for the wishes or suggestions of his colleagues. While such a man should exercise a powerful influence, he may well destroy the future strength of the group by his one-man rule, since his associates will have had no chance to gain experience through the sharing of responsibility.

When should a group employ a "layman" specialist business manager? Among larger groups, the size of the staff and the complexity of organization require far more time, attention and administrative training than can be provided by members of the groups without seriously hampering their professional functions, and the business manager is an essential. However, the business manager cannot operate effectively unless the members of the group are willing to give up certain areas of their own authority to a "layman" management specialist whose qualifications command a salary that will enforce his status.

Up to around fourteen members, a group can theoretically meet effectively in working out policy decisions and operating procedures, with all members participating. Beyond that number, they should recognize that the "committee of the whole" becomes ineffective, and organize themselves in departmental units for the primary stages of determining policy, with operating committees cutting across departmental lines to direct the detailed formulation and application of procedures. These committees must work closely with the business manager in setting up major programs for the decision of the entire group, then must approve the specific programs developed by the manager, and provide general supervision of his application of these programs. Whatever the size

of the group, however simple or elaborate its organization, above everything, all its members must meet together conscientiously and regularly.

2. *Which kind of group should you form?*

(a) *Homogeneous?* General practice lends itself most readily to the homogeneous group, together with those specialties where the need for availability to patients closely approaches general practice—obstetrics being probably the most readily apparent example. The main limitation is to the number of men who can form an effective team; beyond three or four (the optimum group if all are serving the same set of patients) the organization tends to break down into sub-groups or essentially individual practices. The combined factors of population-physician density and market area are important in forming any group, and particularly the homogeneous specialty group. While homogeneous general-practice groups are probably needed in many small- and medium-sized communities, most classes of specialists can find little justification for such organization except in the larger metropolitan centers or where a large market area is extremely under-supplied in their particular specialty.

(b) *Heterogeneous?* The field for the heterogeneous group is obviously much broader than for the homogeneous; as to size, the deciding factor, aside from chance elements such as attrition, is usually that of how complete a service is justified by these same population factors. Basically, the heterogeneous group becomes practicable at around 50,000 market-area population, provided there is not already operative an adequate number and balanced ratio of general and specialized practitioners in that area.

Naturally, these are generalizations, to be considered not as limiting rules, but as probable influences on the success of a particular group project. The "better mouse-trap" principle applies so strongly in the service professions such as medicine that outstandingly successful groups have flourished and will undoubtedly continue to do so where these criteria might have predicted failure.

(c) *Independent?* The basic reason for forming an independent group, in which each physician pursues his own practice and there is a minimal interchange of patients, is to permit the members to share the use of more equipment, services and facilities than they could afford or use efficiently as individuals. Additional motives include investment in building and land, the convenience of vacation coverage, and the availability of informal consultation.

Only if there is a recognized shortage of such facilities in the community as the group might jointly afford does there appear real justification for the independent group. The other motives cited are not in themselves adequate. The commonest causes of failure of independent groups of general practitioners stem from differences in personality and approach among the members. Among specialists, the independent group usually carries the onus of integrated operation (at least in the eyes of outsiders) without the organization which would give it the advantages of true integration both in financial return and in more satisfactory relations with patients.

(d) *Integrated?* We consider this approach to be the best for meeting today's medical needs—when such needs can be met through group practice. Whatever the specialties or other conditions, men going into such a group must accept the basic surrender of their exclusive rights to "their" patients, and accept the responsibility for each other's actions as well.

In a homogeneous group, this amounts to interchangeability of practitioners; each patient is customarily seen in rotation by each of the members, in order that no emergency will find that patient without the best possible care. This approach is probably most feasible in general practice, and in such specialties as obstetrics and pediatrics; beyond the three-member basic group it is not too practical unless the members are divided into teams for the handling of assigned patients.

In a heterogeneous group, integration implies the establishment of a sequential approach to new patients, based on a group nucleus of an internist-surgeon team. The minimum membership is logically two internists (each with some sub-specialization within his field) and two general surgeons. This will permit sufficient flexibility in consultation and surgical assistance in most instances, and protects the group from the probable dissolution which would result from the loss of its only internist or surgeon.

Beyond this nucleus logical expansion is most feasible through adding men in such "mixed" medical-surgical specialties as obstetrics-gynecology and urology, with the more restricted specialties being added as required. As the group expands, additional internists are needed to preserve the basic balance; however, other specialties, such as obstetrics-gynecology, create new points of influx whereby patients enter the group, through direct referrals by patients of the specialists. While it would be injudicious to attempt forcing each new obstetrical patient through the normal chain of referral, the obstetrician must at least make his new patients aware of the group's total approach, so that they may be directed to the internist for future non-obstetrical services.

Unless all patients, whatever their point of entry into the group, understand this basic approach, their efforts at choosing their own specialist — which essentially means self-diagnosis — will lead them

through an irritating and expensive search for the answer to their health problems. Unfortunately, the tendency among patients is to resent the "diagnostic run-around" they experience when this happens, and to lay the blame upon the group. From misunderstandings of this kind arise the major patient-relations and administrative frictions which endanger the success of the integrated group and which the members must most rigorously avoid.

3. *With whom should you form a group?*

Assuming that a physician's professional qualifications are adequate, the major question to be determined is one of personality—the extent to which he is able to work harmoniously with the other members. In the independent group, this becomes a matter of his general compatibility, the characteristics one would seek in a good neighbor. In the integrated group, the question is much more intricate, since each member must sacrifice both his independence and his exclusive right in "his" patients. While most physicians will acknowledge the advantages of interchangeability and shared responsibilities in treating patients, they often act quite differently when faced with the reality of their own powerful emotional attachment to those patients. They may even be unable to break the ties, which are the stronger for being hidden well below the conscious level.

How can this emotional characteristic of physicians be prevented from blocking the functioning of an integrated group? The strength of the attachment can usually be tested during a relatively short period of observation under the stresses of dealing with patients on a mutual basis—a paramount justification for requiring a trial association period either in forming a new group or taking a new member into an established group. Fortunately, through patient and persistent guidance, most physicians can be brought to modify these feelings toward patients, and to achieve a genuine acceptance of the shared relationship within the group; those who cannot should not attempt to remain in group practice.

Since the interpersonal relationships within a group are important, the role played by the doctor's wife is also important. Wives have frequently been blamed (sometimes with cause) for breaking up groups and partnerships. Whatever the reasons given, the most frequent cause is jealousy—usually based on the husband's status in, and income from, the group. It is therefore important to give a prospective member's wife ample opportunity not only to find out in advance whether she likes the community and all of its living, school and social facilities, but to understand precisely what the group is offering her husband in future prospects as well as present income and obligations. Straightforward and realistic discussion is essential to avoid building up false hopes and premature expectations, and especially to avoid the wifely "protective anxiety" which expresses itself as nagging and can turn a young physician against his associates.

Nor can the wife's importance when her husband dies or retires be ignored, even at the earlier time when he joins the group. The emphasis herein on setting up a reasonable procedure for liquidating a partner's interest within the partnership agreement is primarily dictated by consideration of the importance of a wife's position. A wife must know what will be done to protect her as well as the group should her husband die. The pleasant congenial wife who becomes the grasping, demanding widow must be prevented from destroying the partnership through her demands for immediate liquidation. This is an unpleasant eventuality to consider, but it must be guarded against.

4. *How should you finance a group?*

Undoubtedly this question is the first one of interest to physicians approaching the question of forming a group, and the one to which they are generally most impatient to have an answer. It is also the most difficult to outline in general terms since any answer given must be related to the specific factors involved in the given situation, and each factor interacts with all the others.

If there are existing adequate office facilities which can be adapted for the use of the group, perhaps through expansion of offices currently in use by one or more of the prospective members, then the immediate housing problem is not serious. The question is one of exercising ingenuity in modifying and adapting those facilities at moderate cost. However, if the space available is in a medical office building or center that is already occupied by a number of other physicians, the savings achieved in construction cost may be outweighed by the disadvantages in attempting to establish the new organization in the face of strong competition and sometimes direct antagonism. In circumstances where such antagonism is not likely to develop, we are inclined to suggest that a new group "start small," and that it limit its initial financial obligations through renting such space during the period it is testing out the ability of its nucleus of members to work well together.

The second stage for such a group, and the first stage where existing facilities cannot be used, is generally the planning and construction of the group's own building. Here, to reduce the initial investment required, the members and their architect should plan for the future growth of the group to the size desired by adopting a design which permits building additional units as they are required. This demands a well-thought-out program, and a clear statement of the eventual goal to permit the architect

to work effectively. (In our experience, where such projects have not finally met the needs of the enlarged group, it has been because the architect was not permitted to develop his ideas upon any needs beyond those of the immediate present.) Too many groups now find themselves hampered by the results of well-intentioned but short-sighted building programs, forcing them to operate in quarters both inefficient and inconvenient.

The financial requirements of this stage are relatively large so far as the purchase of land and the cost of the architect's plans are concerned, since they must obviously be adequate for the future. But the cost of building and equipment, the major factor, is minimized to current needs, and the dangerous inclination to bring in new men without the most careful consideration, in order to fill the space, is averted.

The amount of capital necessary to approach the first building stage again depends upon circumstances. Even before this, the members of the group must determine their basic office operating overhead, estimate conservatively what portion of it can be met initially from the existing practices (if any) and allocate sufficient funds to meet that overhead for at least three months and preferably for six. (They must also remember to allow for their own personal and living expenses during the first six months.) The remaining capital available can then be applied to the purchase of land, the construction of the building, and the purchase of equipment. It would be ideal if the members of the new group could together meet this entire initial cost in cash—but we seldom find such an ideal, particularly among young physicians. If the group can mobilize around 50 per cent of the capital required, the remainder probably can be borrowed at low interest and on a long-term basis from one of the major life insurance companies that are investing in many such professional building projects. The smaller the proportion of the required capital the group can put up, the higher will become the interest rates they must pay and the shorter the term of repayment demanded.

It quite often happens that one member of a group already owns an office building or other complete facilities, or is able to supply most of the necessary capital initially required. If he owns the facilities, it is usually safer, in the early stages of forming the group, for the group to pay him rental for the use of his space and equipment on a basis sufficient to cover its depreciation and carrying charges, with an option to purchase and take over title at the book value when there is a reasonable assurance of the group's future. The other members then contract by personal notes drawn to him to pay him their individual shares or they borrow the money elsewhere on commercial loans and pay the original owner in a lump sum. The end result should be (if the group is to operate on a basis of equality in decision) that each member owns and shares equally in its assets.

Sometimes, for purposes of financial stability, convenience of admitting new members at a later date, or limiting individual liability, the members of a group will set up an association, a joint venture, or a corporation (profit or non-profit) to act as their "housekeeping" instrument, with their operating partnership paying a rental sufficient to cover all operating costs and carrying charges, or with the individual physicians nominally acting as employees of the association. No general recommendations can be made as to any of these particular courses of action, since their advantages and disadvantages to each individual group must be weighed not only in the light of the immediate financial problems but of that group's long-range goals and intentions, and of the restrictions and limitations placed upon each instrument by federal and state laws, including present and anticipated tax programs. No group should proceed without a full exploration of the facts and future probabilities by the management, tax, and legal counsel of the group, working together. Many are the disappointments and losses suffered by physicians through the dissolution of groups and through unintended financial and tax obligations. Some of the largest and most prominent groups in the country have suffered severely as the result of the tendency of physicians to forget that they are laymen in this field.

5. *Where should you form a group?*

Any new group of physicians should meet a real need of the particular community which the members have chosen. It can either be a basic need for medical care arising from an inadequate number of physicians in that area, or the supplying of a higher level of specialized service than is already available in the community. Fully as important as the present physician-population ratio and characteristics of the community are the growth trends which appear to be in operation. These include not only the obvious questions of organized developments (housing, shopping centers, etc.) and transportation facilities, but the age level, racial composition, and income sources of the present population and their probable future direction. Much of this information may be obtained from local civic groups, from the medical societies, and from population studies by various government agencies.*

Finally, the community should provide social, cultural and educational satisfactions for the physi-

*By the time this reaches publication, the monumental study of physician distribution directed by Dr. Frank G. Kickinson should be available to interested readers. This study, published as Bulletin 94 and 94A of the Bureau of Medical Economic Research, American Medical Association, will provide a detailed analysis of the physician-population ratio in every medical trading area in the United States.

cian and his family. Here again, the physician's wife and children must be considered, and the wife brought into the investigation so that she may share in the decision which will greatly affect her future happiness.

6. *How can you perpetuate a group?*

A related question might be, *Why* should you perpetuate a group? Among the most frequent and valid motives for perpetuation are the following: Maintaining medical service to the community; "immortalizing" the founder's special skills by his disciples and successors; providing for the retirement estate.

In maintaining medical service of high quality, the first requirement is the creation of a sympathetic *group* personality, so that the loyal patient following may remain with the group as its older members retire. The senior men usually have been most successful in building patient loyalty, as through the years experience has taught them effective ways of making patients understand and appreciate their personal interest. They must, then, in bringing new members into the group, find some means of endowing them with this human wisdom so that loyal patients will continue to receive the sympathetic service which will help to retain them for the group.

The first mistake to avoid in bringing new members into an established group (to begin as junior associates) is to wait too long before beginning an active program of recruiting. For example, suppose the senior internist in a group suddenly becomes aware at age 60 or 65 that he should begin turning over some of his work to a younger man, and brings into the group as his junior a recently certified internist, aged 30. Their methods are different, their approach is different, they can hardly even be said to speak the same language. The younger man's recent intensive technical training and often exclusively institutional background make it even more certain that the two will find little in common. The senior is seemingly out of date in his medicine; perhaps he has discarded and forgotten much of the technical and theoretical knowledge which his junior has but recently learned. Even more important, the senior has developed his practical techniques of human relations over so long a period of experiment and adaptation that he cannot recognize there was a time when he didn't know them, and so he cannot understand his junior's real difficulties in dealing with patients as people.

New associates should be brought into a group and their orientation begun before the senior men have passed the age of 50, so that the transfer of the heavy work load can begin around the time when most physicians are at the peak of their capacity, and so that the age-background differential is not too great to permit an effective teacher-student relationship. In his indoctrination, the senior must not only recognize the differences in knowledge and experience, but accept his duty actively to overcome them.

Thus, in a properly maintained sequence of group membership, as the original senior member approaches retirement age, his junior will be at peak capacity and will be starting the indoctrination of a third man of similar age differential. It is recognized, of course, that the difficulties now being experienced by many established groups in maintaining this membership cycle have been the unfortunate results of their inability, owing to the demands of military service and other attrition, to bring in and keep with the group those younger men they have known they needed. In such instances, as younger men who have completed their military service now become available, the seniors find themselves in the difficult position of the senior internist described above. While the situation is far from ideal, it can be surmounted and the continuity of the group preserved if both seniors and juniors will frankly recognize the problems presented, and make it their mutual aim to solve them. Such a frank and realistic approach will go a long way toward avoiding the frictions and misunderstandings which would otherwise develop.

Personal pride in the founding of a group and in the "immortalizing" of the founder's name can often lead a senior man into an extreme insistence upon continuing his activity long after he has in reality ceased effective practice. This may become a highly discouraging deterrent upon the younger men in the group. Yet, as a personal symbol, he may at the same time provide a strongly humanizing factor in the eyes of patients, who gain in assurance and confidence from the comforting thought that the well-loved "old doctor" is still there to watch over his successors. We have seen many groups where the use of the founder's name and his occasional appearances after his retirement have proved extremely helpful; at the same time we have seen that the founder of a group can best serve his own goals (of investment as well as pride) by building an active organization which can operate well without him.

Where the founder of a group has built it to success through his own outstanding innovations in his field, and is recognized as a creative pioneer through his development of special skills and techniques or the establishment and application of superior new methods of therapy, he has more than personal justification in desiring to perpetuate his work. In part, his responsibility to medicine as a whole is fulfilled by his selecting and training worthy associates to carry on his work within his group, a similar but more intensive process than the customary indoc-

trination of associates. In the larger sense, he must augment this personal program by accepting a greater number of associates than are necessary for his own group's needs, with the expectation that most of them should and will leave the group to practice elsewhere, thus to aid in the greater dissemination and availability of his paramount skills.

A strong factor in persuading men to form and join groups has always been the promise they make possible of building up tangible asset values that can readily be realized in cash upon their retirement, or paid to their heirs upon their death. This contrasts strongly with the individual practice, whose "goodwill" or intangible value evaporates almost immediately upon the retirement or death of the physician, whose accounts receivable from patients become difficult or often impossible to collect, and whose facilities and equipment seldom bring more than a "second-hand" price. Membership in a group is thus often referred to as a "physician's social security" and it is important in developing the program for perpetuating the group that this goal be kept always in mind.

Two particular points must be considered, both in formulating the original group agreement and in its application as new members are invited into association. The first is that the terms on which the new physician may buy his share of the group's assets (after the customary trial association period) must not be made too stringent; most young physicians at that particular stage in their careers are in the throes of establishing themselves and their families on a proper living scale, and a schedule that crowds payments to the group into too brief a period may not only demand considerable sacrifices (extending the penury of internship and residency) but might also appear so discouraging as to outweigh the remote future returns on their investment. Important in this respect is the method of valuation set up for the group's assets to determine the amount of investment required. Customarily the most generally equitable basis for all parties concerned is the application of the book (or depreciated) value of assets to determining exact amount of the share to be purchased, with the occasional exception of using an appraised value in instances where, owing to intensive maintenance and only minor obsolescence, a large proportion of the original valuation has been preserved.

The second point of importance in making the group an effective investment for its members is that the method by which the shares of senior men will be paid out to them upon retirement, or to their estates at death, must be established well in advance, together with an exact procedure for determining the dollar value of those shares. The double goal is to provide them a continuing income over a number of years, and at the same time to avert an excessive immediate demand upon the resources of the remaining partners. A reasonable program for such payments must be set up in the initial group agreement, subject to modification as conditions change over the years, but still meeting these two requirements.

Further assurances to perpetuating the group can be provided by specific retirement provisions, which will also allow for optional retirement before a compulsory retirement age. This is indeed a delicate subject to introduce into an existing group of long standing, and in such instances practicality and efficiency may have to be sacrificed to some degree. Few senior men will face directly the question whether they are making as effective use of the facilities they are occupying and the overhead they are incurring as a younger member might, and this attitude often prevents groups from bringing in new men at a time when they are most needed. The establishment of an emeritus status for such senior men has been found helpful by a number of groups, and this approach also helps extend the value of their reputations beyond the date of actual retirement.

For a new group, the problems of establishing and building up the group quite naturally loom much larger in the members' minds than its continuation at the eventual date of their retirement. With all the external factors which could affect or alter their plans, why should they attempt to project them so far into the future? The answer is that only by such advance development of their intentions will they assure themselves of not losing sight of their long-range goals, and be able to direct their policies constructively toward them.